NC DIVISION MH/DD/SAS
CAP-MR/DD SERVICES AUDIT ~ 2007

PROVIDER:	**Audit Date:**
LME:	**Name:**
Control #:	**Service Type:**
Medicaid #:	**Procedure Code #:**
DOB / Age:	**Service Date:**
Record #:	**Service Units Billed:**

RATING CODES:	O = Not Met/No 1 = Met/Yes	6 – No service note 7 = Provider name not available	8 = Repaid before audit list sent 9 = NA	RATING

SERVICE ORDER/PROVIDER ENROLLMENT/SERVICE PLAN/DOCUMENTATION:		
1. a. Was an authorization in place covering this date of service? **b. If "a" is NOT MET, was a request for authorization submitted prior to this date of service?**	**a.** **b.**	
2. Is the provider enrolled with Medicaid to deliver this specific service? **2a. If NOT MET, list dates: FROM_____ TO _____**		
3. Is the service plan current with the date of service? *[QP signature serves as Service Order]* **3a. If NOT MET, list dates: FROM_____ TO_____**		
4. Does the service plan identify the type of service billed? **4a. If NOT MET, list dates: FROM _____ TO_____**		
5. Is the documentation initialed and signed by the person who delivered the service?		
6. Does the service documentation reflect purpose of contact, staff intervention and assessment of progress toward goals?		
7. Does the service documentation relate to the individual's goals as listed in the service plan?		
8. Does the service audited meet the specific requirements from the CAP-MR/DD Manual, section 4.6 Services? (see attached specific requirements, Q8, Auditor's Instructions)		
9. Do the units billed match the duration of service?		
10. Does the documentation reflect treatment for the duration of service?		
TRAINING/QUALIFICATIONS/SUPERVISION (List names of staff not in compliance)		
11. Is there documentation that the staff is qualified/demonstrates knowledge, skills and abilities (per person-centered plan requirements, State rules, provider policy, enhanced service needs) for the service provided?		
12. a. Is an individualized supervision plan in place for PP and/or AP staff? **b. Is the plan implemented?** **c. If "b" is NOT MET list dates: From:_____To:_____**	**a.** **b.**	
13. Was the appropriate Criminal Record check requested prior to this date of service? **a. If NOT MET list dates FROM:_____ TO:_____**		
14. Was a Health Care Personnel Registry check completed, prior to this date of service? **a. If NOT MET list dates FROM:_____ TO:_____**		

COMMENTS:

AUDITOR: